EMPLOYEE INSURANCE PROGRAM
ACCOUNTING DEPARTMENT
REFUND REQUEST

AGENCY NUMBER_____ **AGENCY PROCESSOR**_____ **TELEPHONE #**_____ **DATE SENT**_____

SUBSCRIBER NAME_____ **SSN**_____ **MONTHLY BILL COVERAGE CHANGE APPEARS***_____

REASON FOR OVERPAYMENT_____ **TOTAL AMOUNT DUE**_____

DATE OF DEDUCTION	HEALTH		DENTAL		DENTAL PLUS		OPTIONAL LIFE	
	AMOUNT OF DEDUCTION	CORRECT PREMIUM	AMOUNT OF DEDUCTION	CORRECT PREMIUM	AMOUNT OF DEDUCTION	CORRECT PREMIUM	AMOUNT OF DEDUCTION	CORRECT PREMIUM
	SUBTOTAL:_____		SUBTOTAL:_____		SUBTOTAL:_____		SUBTOTAL:_____	
DATE OF DEDUCTION	**DEPENDENT LIFE SPOUSE**		**DEPENDENT LIFE**		**LONG TERM CARE**		**SUPPLEMENTAL LTD**	
	AMOUNT OF DEDUCTION	CORRECT PREMIUM	AMOUNT OF DEDUCTION	CORRECT PREMIUM	AMOUNT OF DEDUCTION	CORRECT PREMIUM	AMOUNT OF DEDUCTION	CORRECT PREMIUM
	SUBTOTAL: _____		SUBTOTAL:_____		SUBTOTAL:_____		SUBTOTAL:_____	

Note: *If overpayment is due to a coverage change, do not submit the refund request until the correct change has appeared on the bill and/or the payroll deduction has been corrected or stopped. If the refund request form is not filled out correctly, the form will be returned to the agency for correction.